FY 2004 Prospective Payment System Payment Impact File (August 2003 Update):

This file contains data used to estimate FY 2004 payments under Medicare's prospective payment systems (PPS) for hospitals' operating and capital costs. The data are taken from various sources, including the Provider Specific File, the PPS-XV and PPS-XVI cost report Minimum Data Sets, and prior years' impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to PPS published in the Federal Register. This file is available for release after the PPS Proposed and Final Rules are published in the Federal Register, which generally occurs during April (Proposed) and August (Final).

FY 2004 PPS PAYMENT IMPACT FILE

File Pos.	Format	Title	Description
1	$6.	Provider Number	Six character provider number, first two digits identify the State[1]
8	$40.	Hospital Name	From cost reports
49	4.	Average Daily Census (ADC)	From cost reports
54	4.	Number of Beds	From cost reports
59	8.2	Medicare Discharges	From 2002 MEDPAR file (adjusted for transfer cases)[2,3]
68	6.4	Case-Mix Index	Version 21 GROUPER (adjusted for transfer cases)[4]
75	6.4	Operating Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for operating PPS
82	6.4	Capital Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for capital PPS
89	9.7	Capital Outlier Percentage	Estimated capital outlier payments as a percentage of Federal capital PPS payments
99	7.5	Capital Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare capital costs to Medicare covered charges
107	9.7	Disproportionate Share (DSH) Patient Percentage	As determined from cost report and Social Security Administration (SSA) data
117	9.7	Capital DSH Adjustment Factor	Applied to Federal PPS payments

127	9.7	Operating DSH Adjustment Factor	Applied to operating PPS payments
137	8.2	Hospital-Specific Rate	The greatest of the 1982, 1987, or 1996 hospital specific rates (1996 data is for Sole Community Hospitals).
146	$4.	Pre-Reclassification Metropolitan Statistical Area (MSA)	MSA where hospital is actually located, prior to any reclassification decisions by the Medicare Geographic Classification Review Board (MGCRB). Rural areas designated by two digit SSA State codes. [4]
151	$4.	Post-Reclassification FY 2003 MSA (Wage Index)	MSA used for wage index assignment after reclassification by the MGCRB.
156	$4.	Post-Reclassification FY 2003 MSA (Standardized Payment Amount)	MSA used for standardized amount assignment after reclassification by the MGCRB.
161	7.5	Operating Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare operating costs to Medicare covered charges
169	9.7	Operating Outlier Percentage	Estimated operating outlier payments as a percentage of operating PPS payments
179	2.	Provider Type	0 = Short term PPS hospital

			7 = Rural Referral Center 8 = Indian hospital 14 = Medicare-Dependent, Small Rural Hospital 16 = Sole Community Hospital 17 = Sole Community Hospital and Rural Referral Center 21 = Essential Access Community Hospital 22 = Essential Access Community Hospital/Rural Referral Center
182	7.5	Resident-to-ADC ratio	Used to calculate the indirect medical education (IME) adjustment for capital PPS payments
190	$1.	Reclassification Status	Indicates hospitals reclassified by the MGCRB N = Not reclassified R = Reclassified for the standardized payment amount

			W = Reclassified for the wage index B = Reclassified for the standardized payment amount and the wage index L = Reclassified under Section 1886(d)(8) of the Social Security Act
192	2.	Census Division	Based on pre-reclassification MSA assignment 1 = New England 2 = Middle Atlantic 3 = South Atlantic 4 = East North Central 5 = East South Central 6 = West North Central 7 = West South Central 8 = Mountain 9 = Pacific 40 = Puerto Rico
195	6.4	Resident-to-Bed Ratio	Used to determine IME factor for operating PPS payments
202	9.7	Capital IME Adjustment	Based on resident-to-ADC ratio

212	9.7	Operating IME Adjustment	Based on resident-to-bed ratio
222	$6.	Pre-Reclassification Urban/Rural Location	Urban/rural designations based on geographic location prior to reclassification by the MGCRB LURBAN = Large urban area OURBAN = Other urban area RURAL = Rural area
229	$6.	Post-Reclassification Urban/Rural Location	Urban/rural designations after reclassification by the MGCRB (see pre-reclass urban/rural location for key)
236	6.4	Medicare Utilization Rate	Medicare days as a percentage of total inpatient days. (Data not available for all hospitals)
243	9.7	Capital Wage Index	Used to determine geographic adjustment factor
253	9.7	Operating Wage Index	Applied to labor-share of standardized amount
263	9.7	Puerto Rico Capital Wage Index	Used to adjust the Puerto Rico capital rate.
273	9.7	Puerto Rico Operating Wage Index	Used to adjust the labor portion of the Puerto Rico operating standardized amount.

Notes:

[1] SSA State Codes:

01	ALABAMA
02	ALASKA
03	ARIZONA
04	ARKANSAS
05	CALIFORNIA
06	COLORADO
07	CONNECTICUT
08	DELAWARE
09	DISTRICT OF COLUMBIA
10	FLORIDA
11	GEORGIA
12	HAWAII
13	IDAHO
14	ILLINOIS
15	INDIANA
16	IOWA
17	KANSAS
18	KENTUCKY
19	LOUISIANA
20	MAINE
21	MARYLAND
22	MASSACHUSETTS
23	MICHIGAN
24	MINNESOTA
25	MISSISSIPPI
26	MISSOURI
27	MONTANA
28	NEBRASKA
29	NEVADA
30	NEW HAMPSHIRE
31	NEW JERSEY
32	NEW MEXICO
33	NEW YORK
34	NORTH CAROLINA
35	NORTH DAKOTA
36	OHIO
37	OKLAHOMA
38	OREGON
39	PENNSYLVANIA
40	PUERTO RICO
41	RHODE ISLAND
42	SOUTH CAROLINA
43	SOUTH DAKOTA
44	TENNESSEE
45	TEXAS
46	UTAH
47	VERMONT
49	VIRGINIA
50	WASHINGTON
51	WEST VIRGINIA
52	WISCONSIN
53	WYOMING

2 Medicare discharges are adjusted to account for the less-than-full (per diem) payment hospitals receive for cases transferred to another PPS hospital prior to reaching the geometric mean length of stay for the DRG. The adjustment is calculated by accounting for transfers in proportion to the total per diem payment relative to the full DRG amount, calculated as: 1 X (Length of stay prior to transfer plus one day) Geometric Mean LOS), where the result cannot exceed 1.

3 In addition to transfers from one PPS hospital to another, Medicare discharges are adjusted to account for the implementation of section 4407 of the Balanced Budget Act, which required Medicare to pay as transfers discharges from 10 DRGs to postacute care. In this year's update, we expanded the postacute care transfer policy to an additional 21 DRGs and dropped two DRGs from the original 10. This results in a total of 29 DRGs that are affected by this policy. In the case of twenty-six (26) of these DRGs (12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, and 483), transfers to postacute care are paid using the same methodology as transfers from one PPS hospital to another. For three DRGs (209, 210, and 211), payment is equal to half of what the case would get under the PPS to PPS transfer methodology plus the per diem amount, and half of the per diem amount for each additional day of the patient stay, up to the full DRG amount.

4 The case-mix index is also adjusted to account for transfers occurring before the geometric mean length of stay. This adjustment is calculated as: Sum of (DRG Relative Weight X (Transfer Payment Amount) Full DRG Payment Amount)). Transfer adjusted number of Medicare discharges.